An Affiliate of BCD Health Partners

Patient Information /Demographics

Today's Date:_____

Please list dependents, First Name, Last Name, Date of Birth below:

Patient: _____ _____ ____/____/_____

Sibling: _____ _____ ____/____/_____

Sibling: _____ _____ ____/____/_____

Sibling: _____ _____ ____/____/_____

Sibling: _____ _____ ____/____/_____

Patient PCP: □ Dr. Mandalapu □ Dr. Raab □ Meghan Haas, NP
□ Dr. Mirone □ Dr. Monty

Patient's Primary Language: _____

Patient's Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Prefer not to disclose

Patient's Race: □American Indian/ AK Native □Asian □Black or African American
□Native HI/Pacific Island □White □Prefer not to disclose

Parent / Guardian Demographics

Parent 1 First Name:_____ Last Name:_____ DOB:_____

Parent 1 Cell:_____ Parent1 Work Phone:_____

Parent 2 First Name:_____ Last Name:_____ DOB:_____

Parent 2 Cell:_____ Parent2 Work Phone:_____

Guardian's First Name:_____ Last Name:_____ DOB:_____

Address:_____

City:_____ State:_____ Zip:_____

Email Address:_____

Home Telephone:_____

Preferred number for evening reminder calls: □Home □Parent 1 cell □Parent 2 cell

Preferred Pharmacy:_____

City:_____

We require you to have access to the online patient portal for access to forms, online bill paying and secure communication with our office.

Preferred email or mobile number for portal _____

GUARANTOR / INSURANCE INFORMATION

Insurance Carrier Name: _____

Policy / ID Number:_____ Group Number: _____

Effective Date: _____ Employer: _____

Name of Person who has insurance: First _____ Last _____

Address (If different than previously listed)_____

Phone_____ email_____

If individual insurance ID numbers are provided by insurance carrier please list below:

Patient Name_____ ID #_____

Patient Name_____ ID #_____

Patient Name_____ ID #_____

EMERGENCY CONTACT : (in the event the parent(s) cannot be reached)

Contact Name: _____ Relationship:_____ Phone: _____

CONSENT

Consent to release:

I hereby authorize the physicians of this practice to release any and all medical information to the above name insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date if signing until it is revoked in writing. I have read this authorization and understand it.

Consent to assignment:

I hereby assign payment of medical services to this practice to which I am entitled or have incurred for medical and/or surgical expense relative to services rendered here. I understand I am financially responsible to said group for charges not covered by this assignment. I further agree in the event of non-payment to bear the cost of collection, and/or Court cost and reasonable legal fees should this be required.

Consent to treat:

I authorize this practice to provide medical care to my child and authorize treatment of care in my absence if my child is accompanied by the following care giver (check all that apply:)

□ Grandparent(s) / Sibling(s) Name(s): _____

□ Nanny / Babysitter Name(s): _____

□ Other _____ Name(s): _____

PLEASE NOTE: Unless accompanied by a note from a guardian, vaccinations will not be administered to minors.

Signature of Parent / Legal Guardian:_____

Date: _____

☐ I confirm the accuracy of all information on page 1 of this document

☐ I confirm the accuracy of all information on page 2 of this document

BCD Health Partners

160 Pehle Avenue, Suite 302
Saddle Brook, NJ 07663

TEL: (201) 252-8700
FAX: (201) 252-8701

Form F100

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF BCD HEALTH PARTNERS

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone No: _____

_____

I hereby acknowledge that I have received from BCD a copy of the Notice of Privacy Practices of BCD. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how BCD can use and disclose my personal health information both with and without my authorization. I further understand that I may contact Pamela DeNora at 201-252-8700 x215 if I have any questions regarding the contents of this Notice or to file a complaint.

_____ _____

Signature of Patient or Patient's Representative

Date

Waiver Form and Acknowledgement of Receipt of Policies

I acknowledge receipt of the Guide and have been informed of, and hereby attest that I fully understand, my financial responsibility for any balance resulting from non-covered services, or services not covered in-office, by my insurer. I agree to pay the allowed amount of the charge per my insurance company, in the event that my insurer does not pay for these services.

Further, I agree to pay the office fees set out in the Guide and comply with office policies.

Patient(s) Name [please list all in family]: _____
_____
_____
_____

Guarantor / Responsible Party's Name:

_____

Guarantor / Responsible Party's Signature:

_____

Date: _____ / _____ / _____

Please separate this signed form from the Guide and give it to one of our staff at the front desk.

Thank you!